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	nsor's S	· L	(VA File	#) [] (3	SSN or ID)		K LUN(SSN)	(ID)	1 '	sor's S			•				_[[
2. PATIENT'S NAME (Last Name, First Name, Patient's Name	Middle I	nitial)		3. PATIEN MM 01/0	NT'S BIRTH D. DD , YY 01/1929	ATE M		SEX F		ed's name sor's Na		me, Firs	t Name,	, Middle	Initial)		
5. PATIENT'S ADDRESS (No., Street)					T RELATION			IRED		ED'S ADDRE							
Patient's Address				Self	Spouse	Child	Ш	Other	<u> </u>	sor's A	ddres	SS					_
CITY			STATE	8. PATIER	NT STATUS	rried 5	7	Other	CITY							STATE	PATIENT AND INSURED INFORMATION
ZIP CODE TELEPHON	IE (Inclu	de Area	Code)	1		<u> -</u>			ZIP COD	Ξ		TEL	EPHON	IE (INCL	UDE AR	EA CODE)	MA.
				Employ	Stud	ent 📙	Stu	rt-Time udent									_ 6
9. OTHER INSURED'S NAME (Last Name, Fire	st Name	, Middle	initial)	1	TIENT'S CON					RED'S POLIC SOR'S SC							Z
a. OTHER INSURED'S POLICY OR GROUP N	IUMBEF	}			YMENT? (CU					ED'S DATE (·				SEX		
If Known					YES	L	NO			05/05/	1929			X		F	NSI
b. OTHER INSURED'S DATE OF BIRTH SEX					ACCIDENT?												
c. EMPLOYER'S NAME OR SCHOOL NAME					YES ACCIDENT?		Not Applicable c. INSURANCE PLAN NAME OR PROGRAM NAME										
Not Applicable					YES		NO		TRIC								
d. INSURANCE PLAN NAME OR PROGRAM I	NAME			i i	ERVED FOR I		USE		d. IS THE	RE ANOTHE	R HEAL	TH BEN	EFIT PL	LAN?			- A
Not Applicable			OLIDI PTILI		pplicable						NO				omplete it	-	-11
READ BACK OF FC 12. PATIENT'S OR AUTHORIZED PERSON'S to process this claim. I also request paymen below.	SIGNA	TURE I	authorize the	release of a	ny medical or o	other inf			paym	RED'S OR At ent of medica es described	I benefit						
l	3191	$\cap a^{-1}$	ture		DATE				SIG	_{NED} Tac	t:e	nt ?	5	، ماج	ratu	re	\downarrow
			15.	IF PATIENT	HAS HAD SA	ME OF	SIMIL	AR ILLNES		S PATIENT I	JNABLE	TO WC	RK IN C	CURREN	NT ÖĞCÜ	PAŢĮON	
14 DATE OF CURRENT: (ILLNESS (First symptom) OR INJURY (Accident) OR GIVE FIRST DATE MM DD YY 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. I.D. NUMBER OF REFERRING PHYSICIAN								FROM	Lat a	<u>~00</u>	lical	علعـ٢٥)				
17. NAME OF REFERRING PHYSICIAN OR O Treating Provide			17a.		er of REFE der's ID			CIAN	ı	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM DD YY FROM DD C D TO							
19. RESERVED FOR LOCAL USE		ame		11000						20. OUTSIDE LAB? S CHARGES							
										/ES	NO	N	<i>7</i> C	- ا	اندما	ole	
21. DIAGNOSIS OR NATURE OF ILLNESS OF	R INJUR	Y. (REL	ATE ITEMS 1	1,2,3 OR 4	TO ITEM 24E	BY LINE	=)	1		CAID RESUE			SINAL R				
Diagnosis 3.										pplicab		NIIMBE	R				-
2.			4	ı						pplicab							
24. A	В	С		D	ioeo on cui	201150		E	_	F	G DAYS	H EP\$DT	1	J		К	_ z
DATE(S) OF SERVICE From To MM DD YY MM DD YY	Place	Type of Service	(Expla	in Unusual	ICES, OR SUF Circumstance: IODIFIER		D	IAGNOSIS CODE	\$ C⊦	ARGES	OR	Family	EMG	сов		RVED FOR AL USE	ATIC
Dates of Service	N/A	MA	See		mized E	3ill	N	A	Ona	CO.05	NA	N.	MA	NA	27		- BR
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25. FEDERAL TAX I.D. NUMBER SSN	EIN		PATIENT'S A		NO. 27.	ACCEF	PT ASS t. clair	IGNMENT? s, see back	28. TOTA	L CHARGE	1 2	29. AMO	UNT PA	ND	30. BAL	ANCE DUE	-
Not Applic					Cable X YES NO					storar Charge shappicable s Bolance							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)								33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Same as Block									
(I certify that the statements on the reverse apply to this bill and are made a part thereo				Care N	lame an	d				#32							
Douling to Constitute		A	ddress				i										
Provider's Signature									PIN#				GRP#				_
(APPROVED BY AMA COUNCIL ON MED	DICAL S	ERVICE	8/88)	PLEAS	E PRINT O	R TY	PE		/ED OMB-09 /ED OMB-12							, 0-0001 (CHAI	- ириs

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(Medicare #) 2. PATIENT'S NAME (L		onsor's S		(VA File	· L	(SSN	or ID) BIRTH DAT	_	-	123-45-67				\$ 4: J J J	1=141=11		
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5. PATIENT'S ADDRES	SS (No., Street)						ELATIONSH			7. INSURED'S AD	DRESS (No	., Street	:)				
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99999	(555)			Code)	Er	nployed	Full-Tin		Part-Time	2IP CODE 99999					-5555	EA CODE	=)
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										123-45-67	89						
a. OTHER INSURED'S	POLICY OR GROUP I	NUMBER	1		a. EN	MPLOYME	NT? (CURF	RENT OF	R PREVIOUS)	a. INSURED'S DAT	TE OF BIRT	H			SEX		
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b. OTHER INSURED'S MM DD YY	DATE OF BIRTH	SEX	F [7	b. Al	JTO ACCI T	DENT?	<u></u>	PLACE (State)	b. EMPLOYER'S N	IAME OR S	CHOOL	NAME				
c. EMPLOYER'S NAME	OR SCHOOL NAME	Д			c. o1	L THER ACC		Ш"		c. INSURANÇE PL	AN NAME (OR PRO	GRAM	NAME			
						Γ	YES	\square N	10	TRICARE							
d. INSURANCE PLAN	NAME OR PROGRAM	NAME			10d.	RESERVE	D FOR LO	CAL US	=	d. IS THERE ANO	THER HEAL	TH BEN	NEFIT P	LAN?			
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12. PATIENT'S OR AU		SIGNA	TURE 1	authorize th	ne releas	e of any m	edical or oth			13. INSURED'S OF payment of me	dical benefit						for
below.	n. I also request paymer	it of gove	rnment	oeneiits eith	er to my:	sell or to th	ie party wno	accepts	assignment	services descri	bed below.	,					
SIGNED	tyl L	<u> </u>	•			DATE	1/5/	105	>	SIGNED	Sit	U	1	0	<u> </u>		
14 DATE OF CURREN	IT: ILLNESS (First	t symptor	n) OR	15	5. IF PAT	FIENT HAS	S HAD SAMI	E OR SI	MILAR ILLNESS.	16. DATES PATIEN	VT UNABLE	TO WC	ORK IN (CURRE	NT OCCL	IPATION	
	PREGNANCY(LMP)								FROM			10)			
17. NAME OF REFERE	RING PHYSICIAN OH C Smith) I HEH S	SOURCE	. 17		имвен (1-11- 1	F REFERR	ING PH	YSICIAN	18. HOSPITALIZAT	DD I YY		TED TO TO	MM	DD		
19. RESERVED FOR L										20. OUTSIDE LAB	?			RGES			
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21. DIAGNOSIS OR NA	ATURE OF ILLNESS O	R INJUR	Y. (REL	ATE ITEMS	3 1,2,3 C	OR 4 TO IT	EM 24E BY	LINE) -		22. MEDICAID RES	SUBMISSIO	ORK	GINAL F	EF. NO).		
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Attachment 2